DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1197 (Rev. 03/03)

STATE OF WISCONSIN
HFS 107.23, Wis. Admin. Code

WISCONSIN MEDICAID

CERTIFICATION OF NEED FOR SPECIALIZED MEDICAL VEHICLE TRANSPORTATION

All areas of this form must be completed and signed by an evaluator to verify the need for specialized medical vehicle (SMV) transportation. Only a physician, physician assistant, nurse midwife, or nurse practitioner may be an evaluator and sign this form.

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient	2. Wisconsin Medicaid Recipient Identification Number (10 digits)

SECTION II — ELIGIBILITY FOR SPECIALIZED MEDICAL VEHICLE TRANSPORTATION

3. Does the recipient have a medical condition that contraindicates safe travel by common carrier such as bus, taxi, or private vehicle?

- ❑ Yes. Complete Sections III and IV.
- ❑ No. Do **not** complete or sign this form. Instead, refer the recipient to the Medicaid transportation coordinator in his or her county/tribal social or human services department. Please **STOP** here.

Complete all areas in Sections III and IV if this recipient's condition contraindicates safe travel by common carrier.

SECTION III — DIAGNOSIS INFORMATION AND VERIFICATION OF MEDICAL CONDITION

4. I have evaluated this recipient and certify that he or she is (check one):

- ❑ Indefinitely disabled. (See form instructions for a definition.) This form is valid for 365 days from the date signed by the evaluator.
- ❑ Legally blind. This form is valid for 365 days from the date signed by the evaluator.
- ❑ Temporarily disabled. (See form instructions for a definition.) This form is valid for 90 days from the date signed by the evaluator.
  State specific condition:
  State expected duration of disability: days

5. Briefly explain why the recipient's medical condition requires transportation in a specialized medical vehicle:

SECTION IV — MEDICAL CARE PROVIDER INFORMATION

I have evaluated this recipient and certify that he or she has a condition that contraindicates safe travel by common carrier, such as private vehicles or mass-transit services, and requires the use of an SMV for transportation to receive medical services.

6. **SIGNATURE** — Evaluator	7. Date Signed
8. Name — Evaluator (print)	9. Job Title — Evaluator

10. Wisconsin Medicaid Provider Number (eight digits), license number, or Universal Provider Identification Number (UPIN)

For questions about form completion or Wisconsin Medicaid, contact Wisconsin Medicaid Provider Services at (800) 947-9627 or (608) 221-9883.

Reset Form